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Continuing Medical Education in Small Community Hospitals

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FOR A NUMBER OF YEARS, the need for medical audit and the desirability of building a program of continuing medical education (CME) to be based on deficiencies disclosed by audit has been stressed. However, even though these two areas of activity are interrelated, the techniques required in the planning and implementation of each of them is very different indeed. To date, even though continuing medical education is the more important of the two for physicians, much more attention has been devoted to audit—in terms of theory, in literature and in meetings. (In California alone, twelve California Medical Association-California Hospital Association workshop conferences were planned in 1974 and twelve have been scheduled for the first half of 1975. This does not include sessions arranged by the Joint Commission on Accreditation of Hospitals, numbering at least nine from June 1974 to February 1975.) Perhaps it has been assumed that once a need for improvement has been identified and defined, the educational programs needed to fill that need will spring into existence de novo; if so, that type of thinking is in error.

Of course, the nature and management of the educational problem will vary greatly, depending on what sort of hospital and staff one deals with. For those institutions whose major function is academic and whose purpose includes teaching, training and research in addition to patient care, much of the capability for creating such teaching programs is already present as a part of the institution's daily activity. For a small community hospital whose efforts are almost totally consumed by primary patient care, the practical aspects of beginning and sustaining a CME program are very different and have received scant attention.

This paper is an effort to describe some of the major questions generated by the efforts of a small community hospital staff in creating its educational program and some of our answers to those questions. It is intended as a kind of practical guide to "how do you get it started?" for a community hospital with limited educational funds and no full time teaching personnel. The program and principles described have now been employed in our own 135-bed hospital for almost two years and are for the most part results of the lessons learned from numerous false starts. Since most of the hospitals in California have 150 beds or less,[1] it is precisely in this area that we must succeed with continuing medical education if it is to have the impact upon the profession that is expected and desired. The difficulties encountered by most smaller community hospitals are usually a direct outgrowth of the character of the hospital and its staff, meaning (1) small size of hospital with meager financial and physical resources available for the creation and maintenance of these programs, and (2) staff comprised totally of private practicing physicians with resulting limitations in time for the planning and administration of CME programs. The medical staff and hospital engaged in planning these programs encounter almost immediately several types of problems which must be dealt with before any further work can proceed. For example:

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CME Coordinator

Who will coordinate the program, including details such as writing letters to speakers, contracting for films and arranging for slide projectors?

CME Topics

How does one choose the topics for CME sessions?

CME Programs

How and where can one obtain suitable speakers?

What audiovisual materials are available and where can they be obtained?

How can physician attendance and participation be encouraged?

What is the general cost of supporting a CME program in this setting?

Although this list is by no means exhaustive, it provides a sampling of some central questions which must be answered in order to construct programs of this type.

Coordinator

At the start, a major obstacle is finding some person whose schedule will allow time to coordinate educational programs and attend to the details preliminary to any successful, organized educational endeavor. Such details include setting dates, writing letters, arranging for teaching aids, reserving lunches, providing publicity and other similar small—but important and time-consuming —activities. In most instances, a physician would best fill this position by virtue of his medical background, his sensitivity to the needs and desires of fellow physicians and his ability to exchange ideas freely with them almost daily about this subject.

If such a person is available, well and good. However, in the private practice community, the prospects of locating somebody with this interest and the sort of leisure which would permit him to undertake these duties in addition to those already imposed on him by a busy practice is fairly remote. Time becomes the limiting factor, and in the midst of a day crowded with seeing patients, noon hours filled with telephone calls and insurance forms, and evenings scheduled for meetings of various kinds, only rarely is such a person available as a volunteer.

Assigning these responsibilities to an education committee usually is not the answer. Generally it results in an inadequate program because the factors that make it difficult for the private practice community to initiate and promulgate a CME program in the first place are not substantially altered. It fails to shift the burden away from the already overburdened practitioner of medicine, but instead creates another meeting to attend, worsening his time deficit further. Also, under the committee approach, there often is a failure to delegate responsibility specifically, which dilutes authority and breeds inaction and discontinuity.

Since, in our own experience, voluntary efforts proved to be inadequate, our hospital and staff found it expedient to hire a medical coordinator, part of whose task it has become to do those things mentioned above. His responsibilities in a small hospital may well include some in fields other than education—such as audit activities, Professional Standards Review Organization (PSRO) criteria and work related to hospital-provided services (coronary care and intensive care units, inhalation therapy, electrocardiographic facilities, dialysis). But included in his activities and responsibilities is the creation, initiation and maintenance of the CME program for the members of the medical staff. In many instances, he should find it useful to attend most or all department audit meetings and department business meetings in a continuing effort to be close to staff physicians and know their appraisal of their educational needs and their assessment of the CME program's usefulness.

A part-time coordinator may be all that is required. In this way, choosing a practicing physician for the position has the advantages of assuring that the coordinator is alert to the thinking of the private practice community, while not fractionating the staff into hospital-based versus private practice physicians.

Topics

The topics, the form and the manner of presentation used in CME efforts are determined in large measure by the educational needs of the staff, as well as by the resources available for dealing with these needs.

At present, the approach most often used in defining educational needs is first to discover deficiencies, using audit activities in the hospital, and then to base CME programs on their correction. To the degree that the audit is sensitive enough to detect and define true deficiencies in patient care, this principle has merit. But it is fallacious to assume that audit is the only good

determinant of educational direction. Many times the interest of the staff in a given area of education or the personal experience of members of the staff about problem areas within the hospital will serve as an excellent index of educational usefulness. I have on occasion found that the observations made by one perceptive physician serve as well as an extensive audit in determining a worthwhile educational effort. Though audit is valuable as a guide to education, slavish adherence to audit is inappropriate and may lead to omission of worthy suggestions.

Whatever programs are created, they will require enough flexibility to focus on the problems unique to that particular staff. In our own hospital, we have formulated and now use the following broad format for our educational activities: (1) guest lecturers, (2) audiovisual aids and (3) small specialty and subspecialty gatherings.

Programs

Guest Lecturers

Since programs using guest lecturers require more effort in preparation and take more time for presentation, they are offered no more than twice monthly and are designed to appeal to broad segments of our staff. They deal often with topics of basic physiology and basic science (fluid and electrolyte reviews, principles of antibiotic use).

Speakers can be obtained in a number of ways. One excellent method is that of establishing a working arrangement with the chairman of the department of postgraduate education in one or two major teaching institutions (who can make available to you a pool of speakers with expertise in various subjects). Other good sources of lecturers are volunteer health organizations (heart associations and cancer societies) and pharmaceutical companies. However, in my experience these are less useful in supplying speakers on a specific topic.

When areas of deficiency have been identified (by whatever means) and when a topic and date have been decided upon, a letter can be sent from the medical coordinator to the university or assisting organization requesting a speaker for *that particular topic*. Since these are major programs for smaller community hospitals (speakers cost approximately $125), at least 90 minutes should be allotted for them and care should be taken in scheduling times. We have found the hours of 12:30 to 2 pm to be useful because many of our staff are in the hospital at this time.

Other points, suggested by our experience, may contribute to the success of programs:

- Consider an informal conference, perhaps with sandwich lunches, which allows the staff to eat and ask questions while the speaker talks.
- Pay close attention to a schedule; discipline yourself to begin and end when the announced schedule calls for it. The staff quickly becomes discouraged by meetings which drag on indeterminantly, extending into and eroding the afternoon office hours.
- Be certain that you have clearly defined in earlier preliminary correspondence with the speaker the precise areas of need and interest for your staff. He is at a distinct disadvantage if he does not know the desires and capabilities of your staff. Lectures which miss the mark are terribly destructive of future attendance and can be avoided by definite guidance and direction from the medical coordinator.
- Plan a meeting well in advance (one to two months) and publicize it as much as possible. Some techniques which have proved useful for us include having a large bulletin board conspicuously situated in a main hospital corridor, placing smaller bulletin boards at strategic locations (medical records, surgery lounge), publishing a monthly calendar that lists and describes activities for the coming month and even sending notices to the physicians' secretaries at their office with a request that the doctor's schedule be planned so as to permit his attendance at the CME meeting.

Audiovisual Aid Programs

A number of different techniques for programs are available, including videotapes, movies, audiotapes and a combination of tapes and slides. Of these, I have found videotapes and movies of most value and they will be discussed below in more detail.

Audiotapes are not new; they are presently being offered by many organizations[2-4] and cover a wide range of subjects. They have been widely used for years by many members of the medical profession, but in my personal experience they have more application and effectiveness in individual learning than in group or staff educational programs.

Slide programs with written or taped commentary are also available.[5-10] We have used them in a

limited way and have found them to be very useful in specific instances (for example, if the medical department wants a general review of ophthalmology as it applies to primary physicians). However, because their cost is $65 to $75 per program, their use for us has been restricted. Some programed material on professional education is available[7] but its relevance for our staff has been limited and its acceptance has proved to be poor.

Video cassettes and movies are a major source of teaching material for us, designed to appeal to smaller groups and discrete areas of need. Our particular hospital arrangement includes a conference room in which many of our staff eat lunch and which can easily be adapted for a movie or video cassette showing, allowing a presentation during the lunch hour.

Video cassettes are short (20 to 40 minutes long), can be found on a wide variety of subjects enabling one to select them according to a specific need and require a minimal effort to show (using a projector or video screen). They do, however, require that the medical coordinator put the program together well in advance—making the selection from the appropriate catalog, placing the order six to eight weeks beforehand, and scheduling the showing on the calendar. Last but certainly of considerable importance is the fact that video cassettes can be obtained cheaply (see below). Of course, their use requires a video screen. Several different models of these screens are currently marketed, ranging in price from $1,700 to $2,500. My experience in this field is not wide, but it would appear that as long as a video screen will handle ¾-inch tapes, there is little substantial difference among them.[11] This piece of equipment is important and will in the future constitute an increasingly important capability by means of which much of our educational material will be presented.

Tapes can be obtained from two major sources: commercial groups[12-16] and government.[17,18] Although commercial video cassettes frequently are excellent presentations, they have the distinct disadvantage of being expensive and, perhaps worse, are sometimes difficult to tailor to staff needs. If you subscribe to a commercial video cassette service, you take what their offering provdes—and while at times this covers some staff needs, at other times the program may interest only one or two members. Many financial arrangements are available, including rental (approximately $75 per tape for two weeks), sale ($150 per tape) or subscription ($500 to $700 per year for twice monthly programs).

The federal government is a gold mine of inexpensive video cassettes and movies.[17,18] These can be ordered through National Audiovisual Center and Brooke Army Medical Center, both of which publish extensive catalogs. The movies are acquired on loan at no cost while video cassettes can be obtained for $10 by having them tape from one of their master tapes onto a blank tape you send to them. Taping from master tapes affords an opportunity to build up a pool of ten to fifteen hours of cassettes, using a wide variety of master tapes on subjects of particular interest or need to your staff. The cost is minimal. Additionally, the cassettes provide a valuable reservoir of selected educational material which is readily available should a scheduled meeting or film showing be cancelled.

Many other sources for movies are available.[19,20] All arrange for educational films on request and at virtually no cost to the ordering hospital—a feature of paramount importance to a small community hospital with a limited educational budget. However, cassettes have provided us more flexibility than movies since the cassette remains ours until we choose to send it back for retaping, whereas movies have a definite prescheduled showing date and must be returned immediately afterwards. A word of caution regarding both video cassettes and movies: both can vary widely in the quality and manner of presentation. The catalog description and assessment can be very misleading. It is, therefore, advisable when possible to preview them before showing, allowing enough time for a substitute if they should prove to be unsatisfactory.

Specialty Meetings

A third continuing educational activity is using small conferences designed to appeal to specific needs of small groups within the staff (neuroradiology and neuropathology sessions, isotope meetings, coronary care unit conferences). At our hospital, the topics for presentation and discussion have, as a rule, been chosen primarily from material selected by the group concerned as suitable and interesting (as opposed to audit program selection). The number attending is frequently limited, perhaps four to six people.

It is surprising to see how often these conferences are sparked by one or two interested physicians who find time to review cases, select

pertinent x-ray films and slides, and generally prepare for the conference. Nonetheless, a medical coordinator can be very helpful by arranging to have slides made and films available, and generally by taking care of those administrative activities which would otherwise consume the time of the physicians handling the meeting. The principles of adequate notice and attention to strict time limitations noted earlier pertain here. Additionally, providing coffee and rolls can sometimes make early morning meetings more attractive.

In conclusion, I have discussed some of the immediate and practical problems encountered in the effort to generate a continuing medical education program, relating them specifically to a small community hospital in which all, or virtually all, of the medical staff are full-time, private practicing physicians. In so doing, I have described our particular format for continuing education, designed to satisfy differing educational needs within our medical staff. Included were: (1) formal lectures presenting basic material of interest and concern to most segments of a diversified staff, (2) audiovisual material intended to fill smaller, discrete needs of certain segments of our staff and (3) brief subspecialty meetings proposed to deal with very precise, isolated areas of interest for small segments of the staff. Our agenda calls each month for one or two outside speakers, four to five video cassette showings or movies and four to five subspecialty sessions. Our budget for this program is $1,000 to $1,200 per year.

Some principles found to be helpful in implementing all of these have included the following:

- Find a person who is interested in continuing medical education activity to initiate and pursue the mechanical, time-consuming administrative activity necessary for beginning and supervising these programs. If no one with enough time can be found, think seriously about paying somebody enough to enable him to take the time for such a project.
- Give explicit guidance to guest speakers as to subject material.
- Begin and end meetings with close attention to a schedule.
- Plan meetings well in advance and advertise them well, using bulletin boards, monthly calendars and word of mouth.
- Use breakfast and luncheon meetings as much as possible.
- Even though deficiencies indicated by audit are an important foundation for continuing education activity, draw freely and readily upon the experience and expressed desires of members of your staff as an equally vital source of educational programs.

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